TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CLINICS OF NORTH TEXAS

Respondent Name
SOMPO JAPAN INSURANCE COMPANY

MFDR Tracking Number
M4-17-2410-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service is over a year. Every time I call, I get the same answer that the claim is in review and that they would contact the escalation team to get the claim processed... I do not believe that they are processing this claim in a timely manner or giving me information on when it is expect to process."

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that Medical Fee Dispute Resolution is the wrong forum for this dispute as the bill is disputed due to an extent of injury dispute. We are attaching the EOB that shows the bill is disputed due to an extent of injury dispute."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2016	99213-WC	$159.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor seeks reimbursement for disputed date of service March 9, 2016. The EOB presented by the requestor, dated May 17, 2016 indicates that the disputed CPT Code 99213 was denied by the insurance carrier with denial reduction codes:

   - 224-Duplicate Charge
   - 18-Exact duplicate claim/service

   The insurance carrier's response states in pertinent part, "...the bill is disputed due to an extent of injury dispute." The insurance included a copy of an EOB dated, April 27, 2017, dated approximately 17 days after the MDR received date of the DWC060 Request. The EOB presented by the insurance carrier, dated April 27, 2017 indicates that the disputed CPT Code 99213 was denied by the insurance carrier with denial reduction code:

   - D00-Based on further review, no additional allowance is warranted
   - D52-Entitlement to benefits, not finally adjudicated

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary and the EOB dated after the DWC060 received date, are new defenses and are not denial reasons raised during the medical bill review process, as they are not indicated on the Explanation of Benefits dates prior the filing of the MDR DWC060 request. The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary and EOB were presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review. In addition neither party submitted an EOB disputing entitlement to benefits dated prior to the filing of the medical fee dispute. The Division will therefore review the disputed service according to the division rules and guidelines.

2. The requestor seeks reimbursement for disputed date of service March 9, 2016, received by the MDR Section on April 10, 2017.

   28 Texas Administrative Code §133.307(c) (1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the service in dispute is March 9, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 10, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c) (1) (B). The Division concludes that the requestor has failed to timely file date of service March 9, 2016 with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for this date of service.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This finding is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 4, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.